STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155620			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 12/13/2012		
NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS			675 S F	FORD RD VILLE, IN 46077	
(X4) ID PREFIX TAG F0000	SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This visit was for the Inv Complaints IN00119582 IN00120706. Complaint IN00119582 deficiencies related to the cited. Complaint IN00120706 Federal/State deficiencies allegations are cited at F Survey dates: December Facility number: 0005 Provider number: 1556 AIM number: 1002 Survey team: Connie Landman RN TO Census bed type: SNF: 15 SNF/NF: 148 Residential: 67 Total: 230 Census payor type: Medicare: 19 Medicaid: 94 Other: 117 Total: 230	substantiated no e allegations are substantiated, es related to the 282 and F323 r 11, 12, 13, 2012 s 38 20 67290	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This Provider respectfully requests that the 267 plan of correction be considered as the letter of credible allegation and request a desk revie on or after January 12, 2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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57Y411

000538

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

TED
012
(X5) COMPLETION DATE

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Event ID: **57Y411**

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. BUILDING 00		00	COMPLETED	
		155620	B. WIN			12/13/	2012
NAME OF B	AD CHARLED OR CHARLED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			675 S F	ORD RD		
	LLE MEADOWS			ZIONS\	/ILLE, IN 46077		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services provide facility must be propersons in accord written plan of car Based on observing record review, the residents who we had bed and/or coresidents reviewed 6 (Residents B at Findings include 1. The record for reviewed on 12/12 Current diagnoses	UALIFIED PERSONS/PER rided or arranged by the rovided by qualified dance with each resident's re. ation, interview and refacility failed to ensure ere assessed as a fall risk thair alarms for 2 of 4 red for falls in a sample of rnd F). The Resident B was 1/12 at 1:30 P.M.	F02		I. Alarms were placed on both Resident B and Resident F's bed and wheelchairs. Care plans and CNA assignment sheets for both residents were reviewed to ensure all indicated fall prevention interventions were in place. II. All residents will have new fall risk assessments completed. Care plans and interventions will be updated accordingly for all those who trigger as a fall risk. Chart audits and resident observations will be	e	01/12/2013
	non-insulin depe gastroesophagea	ntia, hypertension, ndent diabetes mellitus, I reflux disease, dementia			completed by the Director of Nursing Services or designee to ensure all physician orders regarding	5	
	complaints of pa				bed and chair alarms are present and being followed.		
		essment, dated 12/3/12, nt B was a fall risk and to are plan.			III. Fall risk assessments will be completed at a minimum of quarterly and with significant condition changes. Care plans will be updated with all new		
	Physician Orders was to have a pro	2012, Recapitulation of s indicated the resident essure sensor alarm to the of unassisted rises, 1/27/11.			interventions. CNA assignment sheets will also be updated with all fall interventions. All nursing staff will be re-educated on the facility's fall management program on 12/31/12. Education will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155620	B. WIN			12/13/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8		1			
ZIONOVI	LLE MEADOWS				FORD RD		
ZIONSVI	LLE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
					provided by the Staff Development		
	A health care pla	an, dated 12/6/12,			Coordinator. All falls will be		
	indicated a probl				reviewed by the IDT team the		
		cluded, but were not			following business day to ensure		
		·			appropriate interventions are in		
	limited to, bed a	larm sensor.			place. Nurse Managers or designee	S	
					will review those residents with fall		
	During an observ	vation of Resident B in			interventions listed daily to ensure		
	bed on 12/12/12	at 10:45 A.M., while he			all interventions are in place per the		
		e was no alarm present on			plan of care.		
	his bed.	Paragraphic					
	ilis ocu.				IV. Unit Managers or		
	.	:			designee will complete the Fall		
		iew with LPN #1 on			Management Continuous Quality		
	12/12/12 at 1:30	P.M., the resident was			Improvement tool weekly for four		
	again observed,	and an alarm was not in			weeks, monthly for six months and		
	place. LPN #1 is	ndicated she did not			then per the normal facility CQI		
	know where his				schedule. All areas of		
	Milow where ms	arariii was.			noncompliance will be corrected		
	2 Th 1 C.	n David and Et			immediately upon identification.		
		or Resident Fé was			Director of Nursing Services will		
	reviewed on 12/	13/12 at 10:00 A.M.			review the findings from the		
					Continuous Quality Improvement		
	Diagnoses include	ded, but were not limited			tool weekly to ensure corrective		
	to, diabetes mell	itus, seizures, aphasia,			action has been completed. All		
	hearing loss, par	-			completed Fall Management Continuous Quality Improvement		
	• • •	ia, dementia, and			tools will be reviewed by the IDT		
					team at the facility's monthly CQI		
	depressive disor	der.			meeting. Should the compliance		
					rate fall below a 95% compliant		
	A Fall Risk Asse	essment, dated 11/28/12,			threshold, systematic corrective		
	indicated the res	ident was a fall risk and			actions will be put in place at that		
	to proceed to the	e care plan.			time.		
	_	•					
	The December 1	2012, Recapitulation of					
		-					
	*	s included an undated					
	_	ure alarm to bed and					
	wheel chair at al	l times.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155620	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 12/13	LETED
	PROVIDER OR SUPPLIER	675 S F	ADDRESS, CITY, STATE, ZIP COD FORD RD VILLE, IN 46077	Е	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	A health care plan, dated 7/3/12, indicated a problem of falls. Interventions included, but were not limited to, pressure alarm to bed and pressure alarm to wheel chair. Both dated 3/5/12. During observation of Resident F on 12/12/12 at 1:00 P.M., and again 12/13/12 at 11:00 A.M., chair sensor alarm was present and working. Observation of Resident F's room and bed lacked the presence of a bed alarm. This federal tag relates to complaint IN00120706. 3.1-35(g)(2)				

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Event ID: **57Y411**

Facility ID: 000538

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a, building 00		COMPLETED			
		155620	B. WING			12/13/	2012
					ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP CODE		
7101101/11	LLE MEADOWO				FORD RD		
ZIONSVII	LLE MEADOWS			ZIONS	VILLE, IN 46077		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h)						
SS=D	FREE OF ACCID	ENT					
	HAZARDS/SUPE	RVISION/DEVICES					
	The facility must	ensure that the resident					
	environment rema	ains as free of accident					
	•	ssible; and each resident					
	· ·	e supervision and					
		es to prevent accidents.					
	Based on observ	ation, record review, and	F03	23			01/12/2013
	interview, the fa	cility failed to ensure			I. Alarms were placed	I	
		nysician's orders for			on both Resident B and Resident F's		
	-	llarms had alarms in their			bed and wheelchairs. Care plans		
					and CNA assignment sheets for both	1	
		for 2 of 4 residents			residents were reviewed to ensure		
	reviewed for the use of safety alarms in a				all indicated fall prevention		
	sample of 6 (Res	sidents B and F).			interventions were in place.		
	Findings include	··			II. All residents will hav	е	
	1 111411185 11141444	•			new fall risk assessments		
	1 T1 1 C.	n Davidant D			completed. Care plans and		
		or Resident B was			interventions will be updated		
	reviewed on 12/3	11/12 at 1:30 P.M.			accordingly for all those who trigger		
					as a fall risk. Chart audits and		
	Current diagnose	es included, but were not			resident observations will be		
					completed by the Director of		
	limited to, dementia, hypertension, non-insulin dependent diabetes mellitus,				Nursing Services or designee to		
					ensure all physician orders regarding	g	
		l reflux disease, dementia			bed and chair alarms are present		
		nd agitation, fall with			and being followed.		
	complaints of pa	in.					
					III. Fall risk assessments		
	A Fall Risk Asse	essment, dated 12/3/12,			will be completed at a minimum of		
		nt B was a fall risk and to			quarterly and with significant		
					condition changes. Care plans will		
	proceed to the ca	ire pian.			be updated with all new		
					interventions. CNA assignment		
	The December, 2	2012, Recapitulation of			sheets will also be updated with all		
	Physician Orders	s indicated the resident			fall interventions. All nursing staff		
		essure sensor alarm to the			will be re-educated on the facility's		
					fall management program on		

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLETED	
		155620	B. WIN		12/13/2012		
		<u> </u>	b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			FORD RD		
ZIONSVI	LLE MEADOWS				VILLE, IN 46077		
					1		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	· ·	DATE	
		of unassisted rises,			12/31/12. Education will be		
	originally dated	1/27/11.			provided by the Staff Development		
					Coordinator. All falls will be		
	A health care pla	an, dated 12/6/12,			reviewed by the IDT team the following business day to ensure		
	indicated a prob	lem of falls.			appropriate interventions are in		
	_	cluded, but were not			place. Nurse Managers or designed	25	
	limited to, bed a	·			will review those residents with fall		
					interventions listed daily to ensure		
	During on aleas	votion of Decident Di-			all interventions are in place per the	e	
	_	vation of Resident B in			plan of care.		
		at 10:45 A.M., while he					
	was in bed, there was no alarm present on				IV. Unit Managers or		
	his bed.				designee will complete the Fall		
					Management Continuous Quality		
	During an interv	view with LPN #1 on			Improvement tool weekly for four		
	12/12/12 at 1:30	P.M., the resident was			weeks, monthly for six months and		
		and an alarm was not in			then per the normal facility CQI		
	_	indicated she did not			schedule. All areas of		
	know where his				noncompliance will be corrected		
	Kilow where his	alailli was.			immediately upon identification. Director of Nursing Services will		
					review the findings from the		
		or Resident F was			Continuous Quality Improvement		
	reviewed on 12/	13/12 at 10:00 A.M.			tool weekly to ensure corrective		
					action has been completed. All		
	Diagnoses inclu	ded, but were not limited			completed Fall Management		
	to, diabetes mell	litus, seizures, aphasia,			Continuous Quality Improvement		
	hearing loss, par				tools will be reviewed by the IDT		
		iia, dementia, and			team at the facility's monthly CQI		
	depressive disor				meeting. Should the compliance		
	acpressive disor				rate fall below a 95% compliant		
	A Foll Dials Ass	occment detect 11/20/12			threshold, systematic corrective		
		essment, dated 11/28/12,			actions will be put in place at that		
		sident was a fall risk and			time.		
	to proceed to the	e care plan.					
	The December,	2012, Recapitulation of					
	Physician Order	s included an undated					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/02/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ZIONSVILLE MEADOWS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) order for a pressure alarm to bed and wheel chair at all times. A health care plan, dated 7/3/12, indicated a problem of falls. Interventions included, but were not limited to, pressure alarm to wheel A bed Deficiency Deficiency	AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			00	(X3) DATE COMPL	
A health care plan, dated 7/3/12, indicated a problem of falls. Interventions included, but were not limited to, pressure alarm to bed and pressure alarm to bed and pressure alarm to wheel			155620				12/13/	/2012
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Order for a pressure alarm to bed and wheel chair at all times. A health care plan, dated 7/3/12, indicated a problem of falls. Interventions included, but were not limited to, pressure alarm to bed and pressure alarm to wheel				•	675 S F	ORD RD	•	
wheel chair at all times. A health care plan, dated 7/3/12, indicated a problem of falls. Interventions included, but were not limited to, pressure alarm to bed and pressure alarm to wheel	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
a problem of falls. Interventions included, but were not limited to, pressure alarm to bed and pressure alarm to wheel		_						
chair. Both dated 3/5/12. During observation of Resident F on 12/12/12 at 11:00 P.M., and again 12/13/12 at 11:00 A.M., chair sensor alarm was present and working. Observation of Resident F's room and bed lacked the presence of a bed alarm. This federal tag relates to complaint IN00120706. 3.1-45(a)(2)	a pind ala ch Du 12 at pro Re pro	problem of falls acluded, but were arm to bed and mair. Both dated arming observation of the problem of the pro	s. Interventions te not limited to, pressure pressure alarm to wheel 13/5/12. on of Resident F on P.M., and again 12/13/12 tair sensor alarm was ing. Observation of and bed lacked the alarm.					

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